Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PINE CREEK MEDICAL CENTER
9032 HARRY HINES BLVD
DALLAS TX 75235

Respondent Name

AMERICAN HOME ASSURANCE CO

MFDR Tracking Number

M4-12-2356-01

DWC Claim #: 05037025
Injured Employee: BOBBY LOVINS
Date of Injury: FEBRUARY 26, 2005
Employer Name: VOLT INFORMATION SCIENCES INC
Insurance Carrier #: 002086 002421 WC 01 (41069)

Carrier's Austin Representative Box

Box Number 19

MFDR Date Received

March 13, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The disputed fees should be paid in accordance with TDI-DWC §134.404. Hospital Facility Fee Guideline – Inpatient, MAR value for DRG 468 is $22,910.18, implant cost plus10% $12,309.00. HCP submitted request for reconsideration requesting additional reimbursement on the claim in accordance with the above rule. Upon review, additional reimbursement was allowed in the amount of $603.90, the claim however was still underpaid."

Amount in Dispute: $13,938.13

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We have escalated this request to our managed care vender to verify the claim has been processed according to the Texas State Fee Schedule. Once the bill has finished processing. We will submit our findings."

Response Submitted by: Gallagher Bassett Services, Inc., 8404 International Pkwy #2300, Plano, TX 75093

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 23, 2011 To September 27, 2011	Inpatient Hospital Surgical Services	$13,938.13	$13,872.13

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.

3. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:
   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
   (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."
   (3) If no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of this section, reimbursement shall be determined in accordance with §134.1 of this title (relating to Medical Reimbursement).
4. 28 Texas Administrative Code §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 143 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."
5. 28 Texas Administrative Code §134.404(g) states that "Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission."
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated December 16, 2011
   - 16 — (16) CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION.
   - W1 — (W1) WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.

   Explanation of benefits dated February 15, 2012
   - W1 — (W1) WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.

Issues

1. Can the maximum allowable reimbursement (MAR) amount for the disputed services be determined according to 28 Texas Administrative Code §134.404(f)?
2. Did the facility or a surgical implant provider request separate reimbursement for implantables in accordance with 28 Texas Administrative Code §134.404(g)?
3. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. Review of the submitted documentation finds that the maximum allowable reimbursement (MAR) amount for the disputed services can be determined according to 28 Texas Administrative Code §134.404(f).
2. Review of the submitted documentation finds that separate reimbursement for implantables was requested in accordance with 28 Texas Administrative Code §134.404(g).

Description of Implant per Itemized Statement	Quantity	Amt Billed	Invoice Cost	Cost + 10%
1.7mm Cocr Cable with TI Crimp	1	$2,745.00	$549.00	$549.00 + $54.90 = $603.90
Simplex P with Tobramycin	2	$3,790.00	$349.00/each	$349.00 + $34.90 $383.90 X 2 = $767.80

Tibial Insert Spacer	1	$7,185.00	$1,437.00	$1,437.00 + $143.70 = $1,580.70
Tibial Stem	1	$19,570.00	$3,914.00	$3,914.00 + $391.40 = $4,305.40
Tibial Bsplt	1	$22,660.00	$4,532.00	$4,532.00 + $453.20 = $4,985.20
TOTAL DUE				$12,243.00

3. Reimbursement for the disputed services is calculated in accordance with 28 TAC §134.404(f)(1)(B) as follows: The Medicare facility-specific reimbursement amount including outlier payment amount for DRG 468 is $21,213.13. This amount multiplied by 108% is $22,910.18.The total net invoice amount (exclusive of rebates and discounts) for the disputed implantables is $11,130.00. The total add-on amount of 10% or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission is $1,113.00. The total maximum allowable reimbursement (MAR) is therefore $35,153.18. The respondent previously paid $21,281.05, therefore an additional amount of $13,872.13 is recommended for payment.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $13,872.13.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $13,872.13 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 14, 2012 Date
Signature	Medical Fee Dispute Resolution Officer	June 14, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.